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MT LEGISLATIVE HISTORY

Chapter 798 1991

Bill H _____ S 16 Original bill & hist. ✓C

H. Committee on Business & Economic Development S. Committee on Business & Industry

Hearing Date(s)		Hearing Date(s)	
Jan 22	✓C	Jan 09	✓C
Apr 02	✓C	Jan 10	✓C
_____	___C	_____	___C
_____	___C	_____	___C
Date Out Apr 02	✓C	Jan 10	✓C

Did this bill originate in an interim committee? ___Yes ___No

Committee _____ Report _____

3/11	2ND READING CONCURRED	94	3
3/12	3RD READING CONCURRED	94	3
	RETURNED TO SENATE		
3/15	SIGNED BY PRESIDENT		
3/16	SIGNED BY SPEAKER		
3/16	TRANSMITTED TO GOVERNOR		
3/20	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 120	EFFECTIVE DATE: 3/20/91	

SB 15 INTRODUCED BY GAGE
EXEMPT FROM R.I.T. TAX INDIAN OIL AND GAS ROYALTIES

12/27	INTRODUCED		
12/28	REFERRED TO TAXATION		
12/28	FISCAL NOTE REQUESTED		
1/07	FIRST READING		
1/09	FISCAL NOTE RECEIVED		
1/10	FISCAL NOTE PRINTED		
1/11	HEARING		
1/19	COMMITTEE REPORT—BILL PASSED		
1/21	2ND READING PASSED AS AMENDED	47	0
1/22	3RD READING PASSED	48	0
	TRANSMITTED TO HOUSE		
1/23	FIRST READING		
1/23	REFERRED TO TAXATION		
2/01	HEARING		
3/07	COMMITTEE REPORT—BILL CONCURRED		
3/09	2ND READING CONCURRED	84	5
3/11	3RD READING CONCURRED	87	12
	RETURNED TO SENATE		
3/14	SIGNED BY PRESIDENT		
3/15	SIGNED BY SPEAKER		
3/15	TRANSMITTED TO GOVERNOR		
3/21	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 92	EFFECTIVE DATE: 3/20/91	

SB 16 INTRODUCED BY GAGE
REVISE INSURANCE LAW—MOTOR SERVICE COMPANY LAW
BY REQUEST OF STATE AUDITOR

12/27	INTRODUCED		
12/28	REFERRED TO BUSINESS & INDUSTRY		
1/07	FIRST READING		
1/09	HEARING		
1/11	COMMITTEE REPORT—BILL PASSED AS AMENDED		
1/12	2ND READING PASSED	50	0
1/14	3RD READING PASSED	50	0
	TRANSMITTED TO HOUSE		
1/15	FIRST READING		
1/15	REFERRED TO BUSINESS & ECONOMIC DEVELOPMENT		
1/22	HEARING		
4/02	COMMITTEE REPORT—BILL CONCURRED		
4/05	2ND READING CONCURRED AS AMENDED	91	3
4/06	3RD READING CONCURRED	92	2
	RETURNED TO SENATE WITH AMENDMENTS		
4/17	2ND READING AMENDMENTS NOT CONCURRED	49	0
4/18	CONFERENCE COMMITTEE APPOINTED		
4/19	CONFERENCE COMMITTEE DISSOLVED		
4/19	FREE CONFERENCE COMMITTEE APPOINTED		
4/23	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/24	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	49	0
4/24	3RD READING FREE CONFERENCE COMMITTEE		

	REPORT NO. 1 ADOPTED	49	0
	HOUSE		
4/18	CONFERENCE COMMITTEE APPOINTED		
4/22	CONFERENCE COMMITTEE DISSOLVED		
4/22	FREE CONFERENCE COMMITTEE APPOINTED		
4/23	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/24	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	90	9
4/24	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	95	5
5/03	SIGNED BY PRESIDENT		
5/03	SIGNED BY SPEAKER		
5/03	TRANSMITTED TO GOVERNOR		
5/17	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 798 EFFECTIVE DATE: 10/01/91		

SB 17 INTRODUCED BY BLAYLOCK

GENERALLY REVISE SCHOOL LAWS TO COMPLY WITH SCHOOL FUNDING REFORMS

BY REQUEST OF SCHOOL FUNDING IMPLEMENTATION, LEGISLATIVE OVERSIGHT COMMITTEE ON

12/27	INTRODUCED		
12/28	REFERRED TO EDUCATION & CULTURAL RESOURCES		
1/07	FIRST READING		
1/11	HEARING		
2/07	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/08	FISCAL NOTE REQUESTED		
2/11	FISCAL NOTE RECEIVED		
2/11	FISCAL NOTE PRINTED		
2/12	2ND READING PASSED	49	0
2/13	3RD READING PASSED	47	0
	TRANSMITTED TO HOUSE		
2/14	FIRST READING		
2/14	REFERRED TO EDUCATION & CULTURAL RESOURCES		
3/14	HEARING		
3/18	REVISED FISCAL NOTE PRINTED		
4/02	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
4/05	2ND READING CONCURRED AS AMENDED	92	4
4/06	3RD READING CONCURRED	93	5
	RETURNED TO SENATE WITH AMENDMENTS		
4/17	2ND READING AMENDMENTS CONCURRED	49	0
4/18	TAKEN FROM 3RD READING AND PLACED ON 2ND READING		
4/19	2ND READING AMENDMENTS NOT CONCURRED	49	0
4/23	CONFERENCE COMMITTEE APPOINTED		
4/25	CONFERENCE COMMITTEE DISSOLVED		
4/25	FREE CONFERENCE COMMITTEE APPOINTED		
4/25	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/29	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	48	0
4/30	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	47	0
	HOUSE		
4/23	CONFERENCE COMMITTEE APPOINTED		
4/25	CONFERENCE COMMITTEE DISSOLVED		
4/25	FREE CONFERENCE COMMITTEE APPOINTED		
4/25	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/25	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	93	7
4/25	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	92	8

SENATE BILL NO. 16

INTRODUCED BY GAGE

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO GENERALLY REVISE THE LAWS RELATING TO THE REGULATION OF INSURERS AND MOTOR CLUB SERVICE COMPANIES; DIRECTING THE CODE COMMISSIONER TO CHANGE ANY REFERENCE TO THE TERM "SOLICITOR" TO "INSURANCE PRODUCER" WHEREVER IT APPEARS IN THE MONTANA CODE ANNOTATED; AND AMENDING SECTIONS 33-1-711, 33-2-705, 33-2-708, 33-2-709, 33-3-401, 33-3-431, 33-7-406, 33-17-208, 33-17-603, 33-20-303, 33-20-305, 33-22-502, 33-22-921, 33-22-923, 33-22-924, 33-22-1501, 33-22-1504, 33-22-1513, 33-22-1704, 33-23-302, 61-12-303, 61-12-304, AND 61-12-305, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-711, MCA, is amended to read:

"**33-1-711. Appeals from the commissioner.** (1) An appeal from the commissioner may be taken only from an order on hearing or with respect to a matter as to which the commissioner has refused a hearing. Any person who was a party to the hearing or whose pecuniary interests are directly and immediately affected by any order or refusal and who is aggrieved by an order or refusal may, within 30 days after the order has been mailed or delivered to the persons entitled to receive the same, the commissioner's order denying rehearing or reargument has been so mailed or delivered, or the commissioner's refusal to grant a hearing, appeal from the order on hearing or the refusal of a hearing. Any request for a stay of the commissioner's order must be made within 60 days, to run concurrently with the 30 days for appeal. The appeal must be taken to the district court of Lewis and Clark County by filing written notice of appeal in the court and by filing a copy of the notice with the commissioner, except that in appeals from the suspension or revocation of the certificate of authority of a domestic insurer or of the license of an insurance producer or surplus lines insurance producer, the person taking the appeal may at his option, in lieu of the district court of Lewis and Clark County, take the appeal to the district court of the county of Montana in which the insurer has its principal place of business or the licensee resides.

(2) Upon filing of the notice of appeal, the court has full jurisdiction and shall determine whether the filing operates as a stay of the order or action appealed from.

(3) Within 20 days after filing of the copy of the notice of appeal in his office, the commissioner shall make and return to the court in which the appeal is pending a copy of his order appealed from and a full and complete

INTRODUCED BILL
SB 16

transcript, duly certified by the commissioner, of his record of the hearing upon which the order was issued, together with all exhibits and documentary evidence introduced at the hearing. If the appeal is from an action of the commissioner with respect to which a hearing was refused, the commissioner shall, within the 20-day period, make and return to the court a full and complete transcript, duly certified by him, of all documents on file in his office directly relating to the matter as to which the appeal is taken.

(4) Upon receipt of the transcripts and evidence, the court shall hear the matter ~~de-novo~~ as soon as reasonably possible thereafter. Upon the hearing of the appeal, the court shall consider the evidence contained in the transcript, exhibits, and documents filed by the commissioner, together with additional proper evidence as may be offered by any party to the appeal.

(5) After hearing the appeal, the court may affirm, modify, or reverse the order or action of the commissioner, in whole or in part, or remand the action to the commissioner for further proceedings in accordance with the court's direction.

(6) Costs must be awarded as in civil actions.

(7) Appeal may be taken to the supreme court from the judgment of the district court as in other civil cases to

which the state is a party. A stay of the effectiveness of any judgment may be made only by order of the supreme court upon the giving of security as that court considers proper.

(8) This section does not apply to appeals as to matters covered by chapter 16."

Section 2. Section 33-2-705, MCA, is amended to read:

"**33-2-705. Report on premiums and other consideration -- tax.** (1) Each authorized insurer and each formerly authorized insurer with respect to premiums so received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in form as prescribed by the commissioner showing total direct premium income, including policy, membership, and other fees, premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance, whether designated as a premium or otherwise, received by ~~it~~ a life insurer or written by an insurer other than a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks located, resident, or to be performed in Montana, with proper proportionate allocation of premium as to such property, subjects, or

risks in Montana insured under policies or contracts covering property, subjects, or risks located or resident in more than one state, after deducting from such total direct premium income applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to such policies. As to title insurance, "premium" includes the total charge for such insurance. No deduction shall be made of the cash surrender values of policies. Considerations received on annuity contracts shall not be included in total direct premium income and shall not be subject to tax.

(2) Coincident with the filing of the tax report referred to in subsection (1) above, each such insurer shall pay to the commissioner a tax upon such net premiums computed at the rate of 2 3/4%.

(3) That portion of the tax paid hereunder by an insurer on account of premiums received for fire insurance shall be separately specified in the report as required by the commissioner, for apportionment as provided by law. Where insurance against fire is included with insurance of property against other perils at an undivided premium, the

insurer shall make such reasonable allocation from such entire premium to the fire portion of the coverage as shall be stated in such report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers the premium tax provided by this section shall be payment in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer which fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose upon an insurer who fails to pay the tax required under this section a fine of $100 a day for each day the tax remains unpaid past the due date or 1% of the amount owed in tax, whichever is greater.

(7) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under this section during the year in which such tax liability is accrued."

Section 3. Section 33-2-708, MCA, is amended to read:

"**33-2-708. Fees and licenses.** (1) Except as provided in 33-17-212(2), the commissioner shall collect in advance and the persons served shall pay to the commissioner the following fees:

(a) certificates of authority:

(i) for filing applications for original certificates of authority, articles of incorporation (except original articles of incorporation of domestic insurers as provided in subsection (1)(b)) and other charter documents, bylaws, financial statement, examination report, power of attorney to the commissioner, and all other documents and filings required in connection with the application and for issuance of an original certificate of authority, if issued:

(A) domestic insurers ..... $ 600.00

(B) foreign insurers 600.00

(ii) annual continuation of certificate of authority 600.00

(iii) reinstatement of certificate of authority 25.00

(iv) amendment of certificate of authority 50.00

(b) articles of incorporation:

(i) filing original articles of incorporation of a domestic insurer, exclusive of fees required to be paid by the corporation to the secretary of state 20.00

(ii) filing amendment of articles of incorporation, domestic and foreign insurers, exclusive of fees required to be paid to the secretary of state by a domestic corporation 25.00

(c) filing bylaws or amendment to bylaws where required 10.00

(d) filing annual statement of insurer, other than as part of application for original certificate of authority 25.00

(e) insurance producer's license:

(i) application for original license, including issuance of license, if issued 15.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) temporary license 15.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 15.00

(f) nonresident insurance producer's license:

(i) application for original license, including issuance of license, if issued 100.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) annual renewal of license 10.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 10.00

(g) examination, if administered by the commissioner, for license as insurance producer, each examination 15.00

(h) surplus lines insurance producer license:

(i) application for original license and for issuance of license, if issued 50.00

(ii) annual renewal of license 50.00

(i) adjuster's license:

(i) application for original license and for issuance of license, if issued 15.00

(ii) annual renewal of license 15.00

(j) insurance vending machine license, each machine, each year 10.00

(k) commissioner's certificate under seal (except when on certificates of authority or licenses) 10.00

(l) copies of documents on file in the commissioner's office, per page ..... .50

(m) policy forms:

(i) filing each policy form 25.00

(ii) filing each application, rider, endorsement, amendment, insert page, schedule of rates, and clarification of risks 10.00

(iii) maximum charge if policy and all forms submitted at one time or resubmitted for approval within 180 days 100.00

(n) applications for approval of prelicensing education courses:

(i) reviewing initial application 150.00

(ii) periodic review 50.00

(2) The commissioner shall promptly deposit with the state treasurer to the credit of the general fund of this state all fines and penalties, those amounts received pursuant to 33-2-311, 33-2-705, and 33-2-706, and any fees and examination and miscellaneous charges that are collected by him pursuant to Title 33 and the rules adopted under Title 33.

(3) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded."

Section 4. Section 33-2-709, MCA, is amended to read:

"33-2-709. *Retaliatory fees, taxes, and other obligations.* (1) When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees, in the aggregate, and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Montana insurers or upon the insurance producers or representatives of such insurers which are in excess of such taxes, licenses, and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements,

or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the insurance producers or representatives of such insurers of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the commissioner upon the insurers or upon the insurance producers or representatives of such insurers of such other state or country doing business or seeking to do business in Montana. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Montana insurers or their insurance producers or representatives shall be deemed to be imposed by such state or country within the meaning of this section.

(2) This section shall not apply as to any fees in conjunction with the licensing of insurance producers, personal income taxes, ad valorem taxes on real or personal property, or special purpose obligations or assessments imposed by another state or by an agency of this state other than the department in connection with particular kinds of insurance other than property insurance, except that

deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the commissioner in determining the propriety and extent of retaliatory action under this section.

(3) (a) For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada, shall be that state designated by the insurer in writing filed with the commissioner at time of admission to this state or within 6 months after January 1, 1961, whichever date is the later, and may be any one of the following states:

(i) that in which the insurer was first authorized to transact insurance;

(ii) that in which is located the insurer's principal place of business in the United States;

(iii) that in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

(b) If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States."

Section 5. Section 33-3-401, MCA, is amended to read:

"33-3-401. Home office and records -- penalty for

unlawful removal of records or assets. (1) Every domestic insurer shall have and maintain its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind or kinds of insurance transacted. Records of the insurer's operations and other financial records reasonably related to its insurance operations for the preceding 5 years must be maintained and be available to the commissioner or his duly constituted examiner.

(2) Every domestic insurer shall have and maintain its assets in this state, except as to:

(a) real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this state; and

(b) such property of the insurer as may be customary, necessary, and convenient to enable and facilitate the operation of its branch offices and regional home offices located outside this state as referred to in subsection (4) below.

(3) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant to a plan of merger or consolidation approved by the commissioner under this code or for such reasonable purposes

and periods of time as may be approved by the commissioner in writing in advance of such removal or concealment of such records or assets or material part thereof from the commissioner is prohibited. Any person who removes or attempts to remove such records or assets or such material part thereof from the home office or other place of business or of safekeeping of the insurer in this state with the intent to remove the same from this state or who conceals or attempts to conceal the same from the commissioner, in violation of this subsection, shall upon conviction thereof be guilty of a felony punishable by a fine of not more than $10,000 or by imprisonment in the penitentiary for not more than 5 years or by both such fine and imprisonment in the discretion of the court. Upon any removal or attempted removal of such records or assets or upon retention of such records or assets or material part thereof outside this state beyond the period therefor specified in the commissioner's consent under which the records were so removed thereat or upon concealment of or attempt to conceal records or assets in violation of this section, the commissioner may institute delinquency proceedings against the insurer pursuant to the provisions of chapter 2, part 13.

(4) This section shall not be deemed to prohibit or prevent an insurer from:

(a) establishing and maintaining branch offices or regional home offices in other states where necessary or convenient to the transaction of its business and keeping therein the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by such an office, as long as such records and assets are made readily available at such office for examination by the commissioner at his request;

(b) having, depositing, or transmitting funds and assets of the insurer in or to jurisdictions outside of this state as reasonably and customarily required in the regular course of its business;

(c) making deposits under custodial arrangements as provided by 33-2-604(3)."

Section 6. Section 33-3-431, MCA, is amended to read:

"33-3-431. Borrowed surplus. (1) A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest ~~not--exceeding--6%--per annum~~ at a rate no greater than the rate established in 25-9-205, which interest shall or shall not constitute a

liability of the insurer as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan.

(2) Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement or be the basis of any setoff; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

(3) Any such loan to a mutual insurer shall be subject to the commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within 15 days after date of such filing the insurer is notified of the commissioner's disapproval and the reasons therefor. The commissioner shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is

inadequate.

(4) Any such loan to a mutual insurer or substantial portion thereof shall be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of such loan shall be made by a mutual insurer unless in advance approved by the commissioner.

(5) This section shall not apply to loans obtained by the insurer in ordinary course of business from banks and other financial institutions or to loans secured by pledge or mortgage of assets."

Section 7. Section 33-7-406, MCA, is amended to read:

"33-7-406. Annual statement -- penalty for failure to file ~~or--to-comply. A-society-neglecting-to-file-the-annual statement-in-the-form-and-within-the-time-provided--in--this part-shall-forfeit~~ The commissioner may impose a fine upon a society not to exceed $100 for each day ~~during-which-such neglect-continues,-and,-upon-notice-by-the--commissioner--to that--effect,--its--authority--to--do-business-in-this-state shall-cease-while-such-default-continues~~ after March 1 that a society fails to file the annual statement required by 33-7-404. The fine may not exceed $1,000."

Section 8. Section 33-17-208, MCA, is amended to read:

"33-17-208. Prelicensing education -- basic requirement. (1) (a) A person applying for a license to act

as an insurance producer for property, casualty, and surety insurance shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(b) A person applying for a license to act as an insurance producer for life and disability insurance or as an enrollment representative for a health service corporation shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(2) A person applying for licenses to act as an insurance producer for both the property, casualty, and surety areas and the life and or disability areas must meet the education requirements in all the areas of insurance.

(3) The minimum prelicensing education requirement does not apply to a person who:

(a) has been licensed within the 12 preceding months as an insurance producer in another state that requires prelicensing education and has completed the education in the other state;

(b) seeks a nonresident license, having been licensed as an insurance provider in his state of residence for at least 1 year;

(c) seeks a nonresident license and is from a state having a prelicensing education requirement;

(d) seeks to reinstate a license lapsed for less than 2 years;

(e) seeks a temporary license under 33-17-216; or

(f) is exempt from examination requirements under 33-17-212~~(5)~~(7)."

Section 9. Section 33-17-603, MCA, is amended to read:

"**33-17-603. Certificate of registration.** (1) Except as provided in 33-17-604, a person may not act as or hold himself out to be an administrator in this state unless he holds a certificate of registration as an administrator.

(2) An application for a certificate of registration must be accompanied by a fee of $100. The commissioner shall issue the certificate unless he finds that the applicant is not competent, trustworthy, financially responsible, or of good personal and business reputation or that the applicant has had a previous application for a license denied for cause within 5 years.

(3) The certificate of registration is renewable annually on ~~the date of issue~~ July 1. A request for renewal must be accompanied by a renewal fee of $100.

(4) The certificate of registration may be suspended or revoked if, after notice and hearing, the commissioner finds that the administrator has violated any of the requirements

of this part or that the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

(5) Unless the certification requirement is waived, a person who acts as an administrator without a certificate of registration is subject to a fine of not less than $500 or more than $1,500."

Section 10. Section 33-20-303, MCA, is amended to read:

"**33-20-303. Incontestability.** If any statements other than those relating to age~~,~~ ~~sex,~~ and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to 33-20-305, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means."

Section 11. Section 33-20-305, MCA, is amended to read:

"**33-20-305. Misstatement of age ~~or sex~~.** In an annuity or pure endowment contract, other than a reversionary,

survivorship, or group annuity, there shall be a provision that if the age ~~or sex~~ of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age ~~or sex~~ and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding 6% per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract."

Section 12. Section 33-22-502, MCA, is amended to read:

"**33-22-502. Required provisions of group policies.** Each ~~such~~ group disability insurance policy ~~shall~~ delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has

been furnished to such policyholder or to such person or his beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) a provision that reads:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

Section 13. Section 33-22-921, MCA, is amended to read:

"**33-22-921. Discontinuance or nonrenewal -- alternate policy or certificate -- same insurer.** (1) If a disability insurer discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate to its insureds

within this state, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured enrolls in and pays the premium for the replacing policy or certificate within 31 days after the termination of the replaced policy or certificate.

(2) A disability insurer who discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate shall base its premium for the alternate policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate."

Section 14. Section 33-22-923, MCA, is amended to read:

"**33-22-923. Replacement policy or certificate -- different insurer.** (1) If a disability insurer replaces a medicare supplement policy or certificate, it may not deny benefits under the replacing policy or certificate to an

insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured pays the premium for the replacing policy or certificate when due or within 31 days after the termination of the replaced policy or certificate.

(2) An insurer who replaces a medicare supplement policy or certificate shall base its premium for the replacement policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate.

(4) To receive the benefits of subsections (1) through (3), a person shall submit to the replacing insurer proof of prior coverage, evidence of benefits provided under the previous policy or certificate, and the effective date and the date of termination of coverage under the previous policy or certificate."

Section 15. Section 33-22-924, MCA, is amended to read:

"**33-22-924. Renewal requirement.** (1) If a person pays a renewal premium on the date it is due or within 31 days

after it is due, an insurer may not refuse to renew a medicare supplement policy or certificate unless the insurer:

(a) refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class; and

(b) offers a replacement policy or certificate at actuarially justified rates.

(2) If an insurer refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class, the policies or certificates will remain in force during the grace period stated in the replaced policy or certificate. An insurer's refusal to renew a policy or certificate may not affect a claim that arose under the ~~replaced~~ discontinued policy or certificate during the period in which an insured was confined without interruption to a medical care facility for treatment."

Section 16. Section 33-22-1501, MCA, is amended to read:

"**33-22-1501. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance

coverage offered by the association through the lead carrier.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; and

(b) unless the individual's eligibility is waived by the association, within 6 months prior to the date of application, has been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations, or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal

Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

(10) "Qualified plan" means those health benefit plans certified by the commissioner as providing the minimum benefits required by 33-22-1521 or the actuarial equivalent of those benefits.

(11) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 17. Section 33-22-1504, MCA, is amended to

read:

"**33-22-1504. Association board of directors -- organization.** (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the seven participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; and

(b) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them due to their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 18. Section 33-22-1513, MCA, is amended to read:

"**33-22-1513. Operation of association plan.** (1) Upon acceptance by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Not less than 88% of the association plan premiums paid to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

(3) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.

(4) (a) Each participating member of the association shall share the losses due to claims expenses of the association plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the association plan that exceed the premium payments allocated to the payment of benefits are the liability of the association members. Association

members shall share in the claims expenses of the association plan and operating and administrative expenses of the association in an amount equal to the ratio of:

~~(a)~~(i) the association member's total disability insurance premium received from or on behalf of Montana residents divided by;

~~(b)~~(ii) the total disability premium received by all association members from or on behalf of Montana residents, as determined by the commissioner.

(b) For purposes of this subsection (4), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, or life insurance.

(5) The association shall make an annual determination of each association member's liability, if any, and may make an annual fiscal yearend assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the association members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the association plan and operating and administrative expenses of the association until the association's next annual fiscal yearend assessment. Payment of an assessment is due within 30 days of receipt by an association member of a written

notice of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days is grounds for termination of membership. An association member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year during which disability insurance business ceased. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $10.

(6) Any annual fiscal yearend or interim assessment levied against an association member may be offset, in an amount equal to the assessment paid to the association, against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The insurance commissioner shall, each year the legislature meets in regular session, on or before January 15, report to the legislature the total amount of premium tax offset claimed by association members during the preceding biennium."

Section 19. Section 33-22-1704, MCA, is amended to read:

"**33-22-1704. Preferred provider agreements authorized.** (1) Notwithstanding any other provision of law to the contrary, a health care insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is providing health care coverage, including preferred provider agreements relating to:

(i) the amounts an insured may be charged for services rendered; and

(ii) the amount and manner of payment to the provider; and

(b) issue or administer policies or subscriber contracts in this state that include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).

(2) A preferred provider agreement issued or delivered in this state may not unfairly deny health benefits for health care services covered.

(3) ~~This---part---does--not--require--that--an--insurer negotiate--or--enter--into--agreements--with--any---specific provider--or--class--of--providers.~~ Health care insurers may place reasonable limits on the number or classes of preferred providers that satisfy the standards set forth by the health care insurer. However, insurers may not discriminate against providers on the basis of religion, race, color, national origin, age, sex, or marital status

and shall select preferred providers primarily on but not limited to cost and availability of covered services and the quality of services performed by the providers."

Section 20. Section 33-23-302, MCA, is amended to read:

"**33-23-302. Cancellation or alteration of policy -- increase of premium rates -- sixty days' written notice required.** Any insurer who insures a physician and surgeon, dentist, registered nurse, nursing home administrator, registered physical therapist, podiatrist, licensed psychologist, osteopath, chiropractor, pharmacist, optometrist, or veterinarian, duly licensed ~~as--such~~ under the laws of this state, or a licensed hospital or long-term care facility as the employer of any such person against liability for error, omission, professional negligence, or performance of services without consent ~~shall~~ may not cancel or alter the policy so insuring ~~such~~ the person or increase the premium rates thereon without first providing the insured 60 days' written notice of the insurer's intention to cancel or alter the policy or increase the premium rates."

Section 21. Section 61-12-303, MCA, is amended to read:

"**61-12-303. Requirements for license.** (1) ~~No-license-shall-be-issued-by-the~~ The commissioner may not issue a license to a company until the company has filed with him the following:

(a) a formal application in such form and detail as the commissioner may require, executed under oath by its president or other principal officer;

(b) a copy of the form of its contract;

(c) a certified copy of its charter or articles of incorporation and its bylaws, if any;

(d) a financial statement in such form and detail as the commissioner may require, executed on oath by its president or other principal officer;

(e) a certificate from the ~~state-treasurer~~ commissioner that it has complied with 61-12-304 in all cases where a deposit of cash or a bond is required by this part;

(f) a certificate from the corporation commissioner of the state of Montana, in the event it be a corporation, that it has complied with the corporation laws of said state.

(2) ~~No-license-shall-be-issued-by-the~~ The commissioner may not issue a license to a company until the company has paid to the commissioner $100 as an annual license fee, or the pro rata portion thereof necessary to be paid to the end of the current calendar year from the date of the application for ~~such~~ the license.

(3) ~~No-license-shall-be-issued-by-the~~ The commissioner may not issue a license until the company has satisfied him by ~~such~~ an examination ~~as-he-may-make~~ and ~~such~~ evidence ~~as~~ he the commissioner may require, in his discretion, that

such the company has complied with the laws of the state of Montana and that its management is trustworthy and competent."

Section 22. Section 61-12-304, MCA, is amended to read:

"61-12-304. Deposits required. ~~No--license--shall--be granted~~ The commissioner may not grant a license to a company ~~as-herein-defined-except-as-hereinafter-stated~~ until it has deposited with the ~~state-treasurer~~ commissioner the sum of $25,000 in cash or in lieu thereof a bond in a form prescribed by the commissioner payable to the state of Montana in the sum of $25,000, with surety approved by the commissioner, conditioned upon the faithful performance of its service contracts and payment of any fines or penalties levied against it for failure to comply with this part; ~~provided,-however,--that~~. However, when any company,~~--as herein--defined,-shall-prove~~ proves to the commissioner that it has been in continuous, active operation in the state for a period of more than the preceding 5 years ~~immediately-last~~ past and has a paid membership of more than 5,000 members within the state or that there are more than 5,000 holders of its service contracts within the state and that it is being properly managed, is rendering to its members the services promised to them, and is financially responsible, ~~no--such~~ a cash deposit or bond ~~shall-be~~ is not required while ~~such~~ the company remains in ~~such~~ that condition. The

~~foregoing~~ cash deposit or bond is not ~~required-in-any instance-as~~ a penalty, but is for the protection of the public only."

Section 23. Section 61-12-305, MCA, is amended to read:

"61-12-305. Expiration Continuance of license. Every Subject to payment by January 1 of each year of the annual license fee required under 61-12-303, each license ~~issued hereunder-shall-expire-annually-on-January-1--of--each--year unless--sooner~~ continues in force as long as the company is entitled to the license under this part or until the license is revoked, ~~or~~ suspended, ~~as--hereinafter--provided~~ or otherwise terminated."

NEW SECTION. **Section 24.** **Policy provisions -- conformity with state statutes.** Each policy regulated by this part must contain a provision as follows:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

NEW SECTION. **Section 25.** **Casualty insurance policy -- conformity with state statutes.** A casualty insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision as follows:

Conformity with state statutes. A provision of this

policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

NEW SECTION. **Section 26.** **Property insurance policy -- conformity with state statutes.** A property insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision as follows:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

NEW SECTION. **Section 27.** **Name change -- short form amendment.** Wherever it appears in 33-7-519, 33-17-206, 33-18-210, and 33-18-501 or in insurance laws enacted by the 52nd legislature, the code commissioner is directed to change the term "solicitor" to "insurance producer".

NEW SECTION. **Section 28.** **Codification instruction.** (1) [Section 24] is intended to be codified as an integral part of Title 33, chapter 20, parts 1 and 12, and the provisions of Title 33, chapter 20, parts 1 and 12, apply to [section 24].

(2) [Section 25] is intended to be codified as an integral part of Title 33, chapter 23, part 1, and the

provisions of Title 33, chapter 23, part 1, apply to [section 25].

(3) [Section 26] is intended to be codified as an integral part of Title 33, chapter 24, part 1, and the provisions of Title 33, chapter 24, part 1, apply to [section 26].

-End-

SENATE BILL NO. 16

INTRODUCED BY GAGE
BY REQUEST OF THE STATE AUDITOR

IN THE SENATE

DECEMBER 28, 1990	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & INDUSTRY.
JANUARY 7, 1991	FIRST READING.
JANUARY 11, 1991	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
JANUARY 12, 1991	PRINTING REPORT.
	SECOND READING, DO PASS.
JANUARY 14, 1991	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 50; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

JANUARY 15, 1991	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT.
	FIRST READING.
APRIL 2, 1991	COMMITTEE RECOMMEND BILL BE CONCURRED IN. REPORT ADOPTED.
APRIL 5, 1991	SECOND READING, CONCURRED IN AS AMENDED.
APRIL 6, 1991	THIRD READING, CONCURRED IN. AYES, 92; NOES, 2.
	RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

APRIL 6, 1991	RECEIVED FROM HOUSE.
APRIL 9, 1991	ON MOTION, CONSIDERATION PASSED UNTIL THE 76TH LEGISLATIVE DAY.

APRIL 17, 1991	SECOND READING, AMENDMENTS NOT CONCURRED IN.
	ON MOTION, CONFERENCE COMMITTEE REQUESTED.
APRIL 18, 1991	CONFERENCE COMMITTEE APPOINTED.
APRIL 19, 1991	ON MOTION, CONFERENCE COMMITTEE DISSOLVED.
	ON MOTION, FREE CONFERENCE COMMITTEE REQUESTED AND APPOINTED.
	IN THE HOUSE
APRIL 22, 1991	ON MOTION, FREE CONFERENCE COMMITTEE REQUESTED AND APPOINTED.
	IN THE SENATE
APRIL 23, 1991	FREE CONFERENCE COMMITTEE REPORTED.
APRIL 24, 1991	SECOND READING, FREE CONFERENCE COMMITTEE REPORT ADOPTED.
APRIL 24, 1991	THIRD READING, FREE CONFERENCE COMMITTEE REPORT ADOPTED.
	IN THE HOUSE
APRIL 24, 1991	FREE CONFERENCE COMMITTEE REPORT ADOPTED.
	IN THE SENATE
APRIL 29, 1991	SENT TO ENROLLING.
	REPORTED CORRECTLY ENROLLED.

state.

Closing by Sponsor:

Senator Brown closed. Senator Kennedy deferred any executive action on SB 5 until Senator Lynch returned.

Senate bill 5 passed unanimously by a roll call vote, and was referred to the consent calendar by unanimous vote.

HEARING ON SENATE BILL 16

Presentation and Opening Statement by Sponsor:

Senator Delwyn Gage, District 5, sponsor of the bill, said senate bill 16 was introduced at the request of the state auditor's office.

Proponents' Testimony:

Dave Barnhill, deputy commissioner of insurance, spoke in favor of the bill (See Exhibit 2).

Stanlee Dull, secretary of Montana comprehensive health association, spoke in support of the bill (See Exhibit 3).

David W. Cunningham, hospital administrator, representing the rimrock foundation, spoke in support of senate bill 16 (See Exhibit 4).

Mona Jamison, an attorney representing rocky mountain treatment center, spoke in support of the bill. She proposed an amendment, not in writing, which is to seriously consider an amendment that would make PPO agreements in this state illegal. She then proposed an amendment (See Exhibit 5).

Pat Melby, attorney representing the rimrock foundation, spoke in favor of senate bill 16 and also supported the amendment that Mona Jamison proposed. He also spoke in support of the language which is currently in Senate Bill 16, at a minimum, expressing that the proposal distributed by Jamison is much clearer, with much less opportunity for interpretation or for avoiding allowing a willing provider to enter into a PPO agreement. Preferred provider organization is a fine concept. An insurance company talks to a health care provider and asks them to lower their rates to x amount. The insured will be encouraged to use the facility and throw a deterrent in their contract if they go someplace else. It works fine in large communities and in areas where one insurance company does not have a near monopoly on health care insurance coverage. It works fine in areas where many hospitals and other health care providers are private or profit hospitals are competing with one another and not with nearby rural hospitals. That same concept will not work fine in rural state Montana. There are very few health care providers in Montana and most are not for profit hospitals; they are religious affiliated hospitals, community hospitals, hospitals owned by the government or by hospital

districts. Montana has one health care insurer who does have a near monopoly and under the elements of some anti-trust cases in other states, 55% of the market in health care insurance would have been considered a monopoly. Blue Cross Blue Shield carries possibly 55% of the market.Entering into a preferred provider agreement with one health care facility can have a devastating affect on the others. A preferred provider agreement with an urban hospital could sound the death knell for the smaller, already struggling rural hospitals in the surrounding communities. There are small hospitals near the large metropolitan areas like Helena, Great Falls, Billings, that are having a horrible time competing with the larger hospitals in those larger communities. This preferred provider agreement with a large urban hospital is going to intensify that competition with the small rural hospitals in the surrounding communities. Not only the financial well-being of health care providers are excluded from being preferred providers, but also the freedom of choice of consumers.

Tom Hopgood, representing the commercial health insurance companies doing business in the state of Montana, gave testimony in support of senate bill 16. He does not represent Blue Cross Blue Shield. He commented on section 19, which amends the Montana PPO bill. The idea behind PPO is for a health insurer to be able to contract with a provider, or a number of providers, to provide their services.These providers then become preferred providers. They offer their services to PPO subscribers at a reduced rate. The insurer then signs people up to be members of this arrangement. This is the key to the entire arrangement that a provider or several providers reduce their prices to subscribers. The economic theory is that the more patients will come to these providers that are preferred providers and, although they are providing their services at a lesser price, they make it up in volume. In the 1987 session, there was a movement to insert language into the model PPO bill which would have destroyed the PPO concept. That language is included in the amendment which has been proposed today and it is the willing provider amendment. Any person that provides those services is able to force their way into the preferred provider arrangement.

Jim Ahrens, president of the Montana hospital association, spoke in favor of the bill. The fear is, in the rural hospitals, that someone will take the down share of the margin, come in and say that these are the terms and that is it. It has happened in other states and it happened to Montana. You cannot make it up in volume in rural areas. There is no volume. Rural hospitals are probably the most precarious hospitals financially in this state. thirty are in the red every year. The whole work of the association is trying to keep health care viable and alive to the citizens of this state. anything that tips that in one direction too much eliminates hospitals. Every year one hospital closes. This is a very serious situation.

Tom Ebzery, attorney from Billings, representing St. Vincents hospital spoke in favor of senate bill 16 focusing on section 19. The statute must clearly show that there cannot be discrimination amongst the providers. The is a very critical

issue for our hospitals. Clear language, as suggested by Mona Jamison, should be inserted to prohibit against discrimination against or among providers, particularly when other providers of health services are competitive and clearly qualified to offer these services. A second provider should be willing to meet the terms and conditions established by a health care insurer in PPO, in a planner program, that this provider should have the right to enter into that same similar type of agreement. But in no event should be forced or excluded or precluded from entering this program. There have been other amendments put onto this recently. Wyoming has added a non-discrimination amendment the last session of their legislature. The issue is public policy in this state and if it is public policy in this state to discriminate, it ought to be changed.

Steve Brown, representing Blue Cross Blue Shield of Montana, spoke in favor of the bill. He stated that he has concerns about the bill. The first is on section 1, page 3, line 12. That is the change from de novo hearing requirements at the district court level. That is the existing law under this particular bill. When there is an appeal from the commissioner's decision, it goes to district court and the statute says the district court has to have a de novo trial of the same issues. The appeal to district court is based on the record made at the administrative level. The commissioner is not bound by the rules of evidence when conducting her hearings under this law. It is a matter of policy. The second concern of the bill has to do with section 12, page 22, lines 14 through 19. He stated that he has listened to the commissioner's office on several occasions explain the purpose of this language and they have consistently explained the purpose as being to make master group policies conform tot eh laws of Montana. The language says that the policy is going to be automatically conformed with the laws of the foreign state where that individual now resides. This is not a housekeeping provision. Their concern is the effect on other providers who aren't part of the PPO arrangement. Our concern is to keep health insurance affordable for Montanans.

Opponents' Testimony:

None.

Questions From Committee Members:

Senator Williams commented that this dispels his thinking that all of the insurance companies are abandoning Montana.

Senator Thayer wondered what this does to the rural hospitals. In the rural areas, there is only one hospital in each area, at least in the Great Falls area and there is one in Fort Benton, one in Conrad and one in Chouteau, and so on. He stated that he is trying to figure out if a provider goes on and has a contract in those rural areas with those providers, how then is that going to put those people out of business is it being suggested that Great Falls is the only place that would get such a contract to have the effect on the rural communities.

Pat Melby said that any insurance company especially with a large share of the health policies issues could enter into a PPO contract with Montana Deaconess hospital. They could make that area as large or small as they want. They could make it to simply be the community of Great Falls or they could make it include Cut Bank, Conrad, Shelby, Fort Benton. So that individuals who need health care services can either go ahead and have that service in Cut Bank. In emergency situations they are going immediately to their local hospital, but when having elective surgery and long lengths of stay in the hospital, the patients are going to take the cheapest course.

Randy Cline stated that what occurs when talking about PPO, local providers must have one preferred provider. The issue of rural Montana hospitals, it's not an area of concern, one can only assume, for the commercial carriers. There is no interest in going to Cut Bank and entering into a PPO agreement with their hospital. The PPO agreement is going to be with the big hospital in the urban area.

Senator Thayer stated that only the people who have policies in the immediate Great Falls areas would be offered the opportunity to have the PPO arrangement. He understood that they are not intending to go out and offer this and force rural areas to come into Great Falls for treatment.

Pat Melby stated that anytime you look at the law, you don't look at what somebody who is operating under it intends to do in the future, you look at what they can do under that law. There has been a lot of concern that Blue Cross Blue Shield is going to enter into tone chemical dependency treatment facility for the state of Montana to be the PPO. It can be done under the present law. That is the concern. If you live in Butte, and you need services and the PPO is Frances Mahan Deaconess hospital for chemical dependency in Glasgow you either go to Glasgow or you go someplace else and pay the 25% differential.

Senator Williams asked under the PPO it offers a patient the one hundred a day charge. How is this cost reduction supposed to hurt the efforts of Blue Cross Blue Shield.

Randy Cline answered that it would for one year. Under the principal of PPO, on a very short term basis it works fine, but over a long period of time it does not because essentially the PPO arrangement and that is that each facility is getting 50% of the business. After the first year there is no special deal because nobody has redirected any revenue to a particular provider.

Senator Williams asked if there was a fear that by doing these PPOs that the damage could be done to the second hospital would be great enough to put them out to loose not only one facility, but the price has gone up because then they have the whole market for Great Falls, Missoula, or Billings, Montana.

Randy Cline answered yes, from the other providers perspective that certainly would be a concern. They develop their own PPO with a hospital in Billings, because the other hospitals would have had already gone out and put together an arrangement. What has occurred under those circumstances is that you do then, save additional money on the part of consumers for health care

costs because you have two facilities and you have two different carriers. They are selling competitive PPO products and what is wrong with having competition in terms of the insurance product in a PPO environment. This arrangement that we have as a carrier can be done by any insurance carrier or obviously by any third party administrator, which is already being done. It is a very simple competitive measure.

Senator Williams asked how the hospitals were determined, by negotiating and bidding.

Randy Cline answered that it could be done a number of different ways. If the bid requirements required that a preferred provider arrangement be offered in order for that coverage to be considered through a particular carrier, a PPO was developed, so that the business can operate in Montana. This is the only place Blue Cross does business.

Senator williams asked if there was nay discrimination against those of us in areas that PPOs aren't available. The cost balloons about $400 a month in the school district but we will never have an opportunity to reduce our rates by 15%.

Cline answered that actually he will. The reason is that eventually rural networks will be developed which will do this. the primary care services that are available in that local rural area will be provided in that local rural hospital. But is you need services that are unavailable in that local area, then through a preferred provider arrangement or contract, your employer will be able to take advantage of those discounts that we have in place through our PPO arrangements in the larger communities.

Mona Jamison stated that there are other plans in the structure to meet people whose income does not support more of the cadillac coverage. There are a range of offering of plans and some actually try to cut down on the services to increase the number of insured. The issue that you are facing is one of public policy. Mr. Cline makes our best argument and that is we are going to favor in the cities with two hospitals one hospital by the 25% reduction. She believes that the willing insurer provision puts the competition getting the price down the way the free market is supposed to operate. If the other hospital is willing to buy on to those figures and those particular costs, they should be entitled to.

Senator Williams asked Tom Ebzery if the Blues didn't have the ability to go to Deaconess, would they have an edge with your program at St. Vincent's to go to the county to bid.

Ebzery stated that what he heard was that since St. Vincent's created a PPO with computer claims that they went after Yellowstone employees for 300.

Senator Williams stated that he did not understand Cline's program with the computer claims.

Cline stated that there is another PPO but would welcome if they would change the law and they could need that same situation. Deaconess could do the same.

Senator Williams asked if Mr. Cline would welcome the suggestion of Larry Akey to bring this PPO in on a separate bill.

Mr. Cline stated that he has no problem with having this in

the bill right now.

Senator Thayer stated that there were three minor suggestions made on the housekeeping portion of the bill and perhaps the auditor's office could respond to them.

Dave Barnhill stated the state auditor's office agreed with an amendment to section 1 that would require that their hearings conform to the rules of evidence. That is no problem whatsoever. With respect to section 12, the language makes claim that conformity to the laws of the state would mean conformity to the laws of Montana because a master group policy is issued in Montana. What triggers the application of the law is the big fat policy becomes effective and the insured would reside in Montana at that time anus the policy would conform to the laws of Montana. Even if the insured at a later date moves to another state the policy would still conform to the laws of Montana and not some other state. The other concern was with section 26 where there is a conformity to state statute and a suggestion that instead of having to parrot that language, equivalent language could be used.

Bart Campbell stated that he had an amendment which came through with some additions he had to make that could have been done as a re-do. He didn't get to them in time so he had to do an amendment. They came from the department and they went over these, but did not go through them section by section.

Senator Williams stated that he could give us a summary of what those will do to the bill, particularly because for the most part those are noncontroversial.

Senator Gage urged that as they look at this bill to give great weight to perhaps putting section 19 in a separate bill.

Closing by Sponsor:

Senator Gage closed. Senate bill 16 passed unanimously with amendments.

ADJOURNMENT

Adjournment At: 12:30 p.m.

J.D. LYNCH, Chairman

DARA ANDERSON, Secretary

JL/sc

BU010991.SM1

reason of this is to be sure that we avoid any duplication of branches in cities as defined in this bill.

Proponents' Testimony:

John Cadby, with the Montana bankers association testified that the bill simply makes it clear that there is only branch in a barren town within the county or neighboring county of the headquarter bank. There is four branches that have been so created in the past two years since the 1989 session.

Opponents' Testimony:

None

Questions From Committee Members:

Senator Lynch wondered if this had any adverse affects on Butte, or Anaconda because they do not have counties and cities.

John Cadby answered by saying that this would not have any adverse affects on Butte or Anaconda. Butte and Anaconda both have banks in these cities.

Senator Noble wondered if the bill passed last year was a disaster to some portions.

John Cadby answered by saying the affect it has had today is the first bank system merged into one bank in Billings. So the first bank in Helena is technically a branch of the headquarter bank in Billings. The first interstate banks in Kalispell and Great Falls have merged into one bank in Kalispell. So the first interstate bank in Great Falls is now a branch of Kalispell.

Joe Thares, international independent bankers, commented that John covered the major activity of the bill with exceptions of maybe three that may merge in the future.

Senator Gage asked if there is a definition of city in the banking laws.

John Cadby answered by saying the definition of city in HB 151 means a city, town, or municipality incorporated or unincorporated that is an aggregation of inhabitance and structures sufficient to constitute a distinct place.

Closing by Sponsor:

Senator Swift asked to give the bill a due pass. By unanimous vote SB 20 was given a due pass.

HEARING ON AMENDMENTS ON SB 16

Presentation and Opening Statement by Sponsor:

Bart Campbell, researcher for Business and Industry, presented the amendments that he prepared (See Exhibit 1).

Proponents' Testimony:

None

Opponents' Testimony:

None

Questions From Committee Members:

Senator Thayer asked if there was more things added to the amendments than discussed in the committee hearing.

Bart Campbell replied that Susan Witte and Dave Barnhill had these amendments and described the house keeping of it. They actually explained those sections that were in their amendments in their testimony yesterday, January 9, 1991.

Senator Thayer asked on page 22 lines 14-19 how Bart changed the wording.

Bart Campbell replied that he hadn't changed anything on these lines because the last that he had recalled there had been a question about what this meant. Dave Barnhill said what that meant is the state of Montana. He did not hear anybody say that they did not like that section, so he did not change that section.

Closing by Sponsor:

Senator Lynch entertained a motion to amend SB 16 with the suggested amendments.

Senator Williams motioned to amend.

The amendments passed 8 of 9.

Senator Williams motioned to due pass SB 16 as amended.

Senate bill 16 passed unanimously with amendments.

ADJOURNMENT

Adjournment At: 11:20 a.m.

J.D. LYNCH, Chairman

DARA ANDERSON, Secretary

JL/da

DATE 1/10/91
BILL NO. SB 16

Amendments to Senate Bill No. 0016
First Reading Copy

Requested by Gage
For the Committee on Business and Industry

Prepared by Bart Campbell
January 10, 1991

1. Title, line 10.
Strike: "AND"

2. Title, line 10.
Following: "SECTIONS"
Insert: "33-1-704,"

3. Title, line 11.
Following: "33-7-406,"
Insert: "33-17-102,"

4. Title, line 13.
Following: "33-22-1504,"
Insert: "33-22-1511, 33-22-1512,"

5. Title, line 13.
Following: "33-22-1513,"
Insert: "33-22-1514, 33-22-1515, 33-22-1516, 33-22-1521,"

6. Title, line 14.
Strike: "33-22-1704,"

7. Title, line 15.
Following: "MCA"
Insert: "; and repealing section 33-22-1522, MCA"

8. Page 22, line 14.
Following: "provision"
Insert: "or the equivalent thereto"

9. Page 26, lines 1 and 2.
Following: "association"
Strike: "through the lead carrier"
Insert: "that is certified by the association as required by 33-22-1521"

10. Page 27, lines 18 through 21.
Strike: subsection (10) in its entirety
Renumber: subsequent subsection

11. Page 31, line 21 through page 33, line 3.
Strike: Section 19 in its entirety
Renumber: subsequent sections

12. Page 34, line 23.
Following: "license"
Insert: "to a company"

13. Page 35, line 24.
Following: "~~such~~"
Insert: "the commissioner may not require"

14. Page 35, line 24.
Following: "~~be~~"
Strike: "is not required"

15. Page 36, line 15.
Following: "provision"
Insert: "or the equivalent thereto"

16. Page 36, line 24.
Following: "provision"
Insert: "or the equivalent thereto"

17. Page 37, line 8.
Following: "provision"
Insert: "or the equivalent thereto"

18. Page 37, following line 13.
Insert: "

Section 26 Section 33-17-102, MCA, is amended to read:

"33-17-102. Definitions. As used in this title, the following definitions apply:

(1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for fee or commission investigates and negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer. The term does not include a:

(a) licensed attorney who is qualified to practice law in this state;

(b) salaried employee of an insurer or of a managing general agent; or

(c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster.

(3) (a) "Administrator" means a person who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on such coverage.

(b) The term does not mean:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued

and delivered by it in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

(B) a health service corporation as defined in 33-30-101;

(iv) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

(v) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of the trust;

(vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

(viii) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

(ix) a bank, credit union, or other financial institution that is subject to supervision or examination by federal or state banking authorities;

(x) a company that issues credit cards and that advances for and collects premiums or charges from its credit card holders who have authorized it to do so, if the company does not adjust or settle claims; or

(xi) a person who adjusts or settles claims in the normal course of his practice or employment as an attorney and who does not collect charges or premiums in connection with life or disability insurance or annuities.

(4) "Administrator license" means a document issued by the commissioner that authorizes a person to act as an administrator.

(5) "Consultant" means a person who for a fee examines, appraises, reviews, or evaluates an insurance policy, annuity, or pension contract, plan, or program or who makes recommendations or gives advice on an insurance policy, annuity, or pension contract, plan, or program.

(6) "Consultant license" means a document issued by the commissioner that authorizes a person to act as an insurance consultant.

(7) "Controlled business" means insurance procured or to be procured by or through a person upon the life, person, property, or risks of himself, his spouse, his employer, or his business.

(8) "Individual" means a private or natural person, as distinguished from a partnership, corporation, or association.

(9) "Insurance producer", except as provided in 33-17-103:

(a) means:

(i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

(A) policies of insurance for risks residing, located, or to be performed in this state; or

(B) membership contracts as defined in 33-30-101;

(ii) a managing general agent. For purposes of this definition, a "managing general agent" is a person who, on behalf of an insurer, exercises general supervision over the business of the insurer in this state <u>or in any other state</u>, including the authority to contract with an insurance producer for the insurer

and terminate those contracts.

(b) does not mean a customer service representative. For purposes of this definition, a "customer service representative" means a salaried employee of an insurance producer who assists and is responsible to the insurance producer.

(10) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(11) "Person" means an individual, partnership, corporation, association, or other legal entity.

(12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."

Section 27. Section 33-22-1511, MCA, is amended to read:

"**33-22-1511. Minimum benefits of association plan.** The association through the association plan shall offer a policy that provides at least the benefits ~~of a qualified plan as~~ required by 33-22-1521."

Section 28. Section 33-22-1512, MCA, is amended to read:

"**33-22-1512. Association plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five ~~largest~~ insurers with the largest premium amount of individual ~~qualified plan~~ plans of major medical insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. ~~The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer, the rates charged by the insurer for each type of plan offered by the insurer, and any other information the commissioner considers necessary.~~ The association shall utilize generally acceptable actuarial principles and structurally compatible rates."

Section 29. Section 33-22-1514, MCA, is amended to read:

"**33-22-1514. Administration of association plan -- rules.** ~~(1) Any member of the association may submit to the commissioner policies to be proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.~~

~~(2)~~(1) ~~Upon the commissioner's approval of the policy forms and contracts submitted, the association shall select policies and contracts by a member or members of the association to be the association plan.~~ The association shall select one lead carrier to issue the ~~qualified plans~~ association plan. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier

must be based upon criteria established by the board of directors.

~~(3)~~(2) The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least 3 years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period is considered an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided in subsection ~~(2)~~(1) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is approved, on or before the end of the 3-year period.

~~(4)~~(3) The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

~~(5)~~(4) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

~~(6)~~(5) The lead carrier shall pay all claims pursuant to this part and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

~~(7)~~(6) The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~(8)~~(7) The lead carrier is, when carrying out its duties under this part, an independent contractor for the association and is individually liable for its actions, subject to the laws of this state."

Section 30. Section 33-22-1515, MCA, is amended to read:

"**33-22-1515. Solicitation of eligible persons.** (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of

this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner which facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of ~~qualified~~ the association ~~plans~~ plan. The lead carrier shall pay an insurance producer's referral fee of $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid ~~to~~ by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 31. Section 33-22-1516, MCA, is amended to read:

"**33-22-1516. Enrollment by eligible person.** (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that he fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.

(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan."

Section 32. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. ~~Qualified~~ Association plan -- minimum benefits.** A plan of health coverage must be certified as a ~~qualified~~ association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; and

(l) services of a licensed home health agency, up to a maximum of 180 visits per year.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(x) complications to a newborn, unless no other source of coverage is available;

(xi) sterilization or reversal of sterilization;

(xii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction."

Section 33. Section 33-1-704, MCA, is amended to read:

"**33-1-704. Hearing procedure.** (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) Except as provided in 33-31-404, rules of pleading ~~or~~

COMMITTEE ON BUSINESS & INDUSTRY

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppo
Wilson Leary	MBA - Helena	SB 20	X	
Dave Bandel	Insurance dept	SB 16 SB 2	X	
Mary McCue	MTB Helena	SB20	X	
Joe Thares	MT. IND. BANKERS	SB 20	X	
John T Cadby	MT Bankers Assn	SB 20	X	

(Please leave prepared statement with Secretary)

~~evidence~~ need not be observed at any hearing, but the rules of evidence must be observed.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

NEW SECTION. **Section 34. {standard} Repealer.** Section 33-22-1522, MCA, is repealed."

BUSINESS & INDUSTRY COMMITTEE

52nd. LEGISLATIVE SESSION -- 1991 Date 1/16/91

NAME	PRESENT	ABSENT	EXCUSED
1 Senator Bruski	X		
2 Senator Franklin	X		
3 Senator Gage	X		
4 Senator Hager	X		
8 Senator Kennedy	X		
9 Senator Lynch	X		
5 Senator Noble	X		
6 Senator Thayer		X	X
7 Senator Williams		X	X

Each day attach to minutes.

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 1/10/91 Bill No. SB16 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: DUE PASS SB16 (WITH ADMENDMTS

1987

adjusts or settles claims on such coverage.

(b) The term does not mean:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

(B) a health service corporation as defined in 33-30-101;

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(4) "Administrator license" means a document issued by the commissioner that authorizes a person to act as an administrator.

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(7) "Insurance" means insurance procured or to be procured by a person about the life, person, property, [illegible] his employer, or his business.

(8) "Individual" means a private or natural person, as distinguished from a partnership, corporation, or association.

(9) "Insurance producer", except as provided in 33-17-103:

(a) means:

(i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

(A) policies of insurance for risks residing, located, or to be performed in this state; or

(B) membership contracts as defined in 33-30-101;

(ii) a managing general agent. For purposes of this definition, a "managing general agent" is a person who, on behalf of an insurer, exercises general supervision over the business of the insurer in this state or in any other state, including the authority to contract with an insurance producer for the insurer and terminate those contracts.

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(12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."

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cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

NEW SECTION. Section 34. {standard} Repealer. Section 33-22-1522, MCA, is repealed."

Renumber: subsequent sections

Signed: J.D. Lynch
John "J.D." Lynch, Chairman

~~the insurer for each type of plan offered by the insurer, and any other information the commissioner considers necessary.~~ The association shall utilize generally acceptable actuarial principles and structurally compatible rates."

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"33-22-1514. Administration of association plan -- rules. ~~(1) Any member of the association may submit to the commissioner policies to be proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.~~

~~(2)~~(1) ~~Upon the commissioner's approval of the policy forms and contracts submitted, the association shall select policies and contracts by a member or members of the association to be the association plan.~~ The association shall select one lead carrier to issue the ~~qualified plans~~ association plan. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board of directors.

~~(3)~~(2) The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least 3 years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period is considered an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided in subsection ~~(2)~~(1) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is approved, on or before the end of the 3-year period.

~~(4)~~(3) The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

~~(5)~~(4) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

~~(6)~~(5) The lead carrier shall pay all claims pursuant to this part and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

~~(7)~~(6) The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~(8)~~(7) The lead carrier is, when carrying out its duties under this part, an independent contractor for the association and is individually liable for its actions, subject to the laws of this state."

Section 30. Section 33-22-1515, MCA, is amended to read:

"33-22-1515. Solicitation of eligible persons. (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner which facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of ~~qualified~~ the association ~~plans~~ plan. The lead carrier shall pay an insurance producer's referral fee of $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid ~~to~~ by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 31. Section 33-22-1516, MCA, is amended to read:

"33-22-1516. Enrollment by eligible person. (1) The

HOUSE OF REPRESENTATIVES

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

ROLL CALL DATE April 2, 1991

NAME	PRESENT	ABSENT	EXCUSED
REP. JOE BARNETT	✓		
REP. STEVE BENEDICT	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. ALVIN ELLIS, JR.	✓		
REP. STELLA JEAN HANSEN	✓		
REP. H.S."SONNY" HANSON	✓		
REP. TOM KILPATRICK	✓		
REP. DICK KNOX	✓		
REP. DON LARSON	✓		
REP. SCOTT MCCULLOCH	✓		
REP. BOB PAVLOVICH		✓	
REP. JOHN SCOTT	✓		
REP. DON STEPPLER	✓		
REP. ROLPH TUNBY	✓		
REP. NORM WALLIN	✓		
REP. SHEILA RICE, VICE-CHAIR	✓		
REP. BOB BACHINI, CHAIRMAN	✓		

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; and

(l) services of a licensed home health agency, up to a maximum of 180 visits per year.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for

association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that he fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.

(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan."

Section 32. Section 33-22-1521, MCA, is amended to read:

"33-22-1521. ~~Qualified~~ Association plan -- minimum benefits. A plan of health coverage must be certified as a ~~qualified~~ association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than $100,000.

STANDING COMMITTEE REPORT

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill 16 (first reading copy -- white), respectfully report that Senate Bill 16 be amended and as so amended do pass:

1. Title, line 10.
Strike: "AND"

2. Title, line 10.
Following: "SECTIONS"
Insert: "33-1-704,"

3. Title, line 11.
Following: "33-7-406,"
Insert: "33-17-102,"

4. Title, line 13.
Following: "33-22-1504,"
Insert: "33-22-1511, 33-22-1512,"

5. Title, line 13.
Following: "33-22-1513,"
Insert: "33-22-1514, 33-22-1515, 33-22-1516, 33-22-1521,"

6. Title, line 14.
Strike: "33-22-1704,"

7. Title, line 15.
Following: "MCA"
Insert: "; and repealing section 33-22-1522, MCA"

8. Page 22, line 14.
Following: "provision"
Insert: "or the equivalent thereto"

9. Page 26, lines 1 and 2.
Following: "association"
Strike: "through the lead carrier"
Insert: "that is certified by the association as required by 33-22-1521"

10. Page 27, lines 18 through 21.
Strike: subsection (10) in its entirety
Renumber: subsequent subsection

11. Page 31, line 21 through page 33, line 3.
Strike: Section 19 in its entirety

SB 1/10 2:50

the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(x) complications to a newborn, unless no other source of coverage is available;

(xi) sterilization or reversal of sterilization;

(xii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction."

Section 33. Section 33-1-704, MCA, is amended to read:

"33-1-704. Hearing procedure. (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) Except as provided in 33-31-404, rules of pleading ~~or evidence~~ need not be observed at any hearing, but the rules of evidence must be observed.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall

Renumber: subsequent sections

12. Page 34, line 23.
Following: "license"
Insert: "to a company"

13. Page 35, line 24.
Following: "~~such~~"
Insert: "the commissioner may not require"

14. Page 35, line 24.
Following: "~~be~~"
Strike: "is not required"

15. Page 36, line 15.
Following: "provision"
Insert: "or the equivalent thereto"

16. Page 36, line 24.
Following: "provision"
Insert: "or the equivalent thereto"

17. Page 37, line 8.
Following: "provision"
Insert: "or the equivalent thereto"

18. Page 37, following line 13.
Insert: "

Section 26 Section 33-17-102, MCA, is amended to read:

"33-17-102. Definitions. As used in this title, the following definitions apply:

(1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for fee or commission investigates and negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer. The term does not include a:

(a) licensed attorney who is qualified to practice law in this state;

(b) salaried employee of an insurer or of a managing general agent; or

(c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster.

(3) (a) "Administrator" means a person who collects, charges, or receives [illegible]

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 1/10/91 Bill No. _____ Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: AMEND SB16 PASSED

1987

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT

Call to Order: By CHAIRMAN BOB BACHINI on January 22, 1991, at 8 a.m.

ROLL CALL

Members Present:
Bob Bachini, Chairman (D)
Sheila Rice, Vice-Chair (D)
Joe Barnett (R)
Steve Benedict (R)
Brent Cromley (D)
Tim Dowell (D)
Alvin Ellis, Jr. (R)
Stella Jean Hansen (D)
H.S. "Sonny" Hanson (R)
Tom Kilpatrick (D)
Dick Knox (R)
Don Larson (D)
Scott McCulloch (D)
Bob Pavlovich (D)
John Scott (D)
Don Steppler (D)
Rolph Tunby (R)
Norm Wallin (R)

Staff Present: Paul Verdon, Legislative Council
Jo Lahti, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Announcements/Discussion: CHAIRMAN BACHINI said the committee would hear HB 223, SB 45, SB 16 and would postpone hearing HB 261 to a later date.

HEARING ON SENATE BILL 16

Presentation and Opening Statement by Sponsor:

SEN. GAGE said this bill comes from the State Auditor. In the Senate conflicting testimony was heard in regard to Section 19 so it was decided to remove that section. They requested a committee bill to deal with the preferred provider section. The old Section 19 is stricken and subsequent sections are renumbered. A couple other changes were made in the Senate but were not very significant.

Proponents' Testimony:

Dave Barnhill, Deputy Commissioner of Insurance, provided written testimony. EXHIBIT 1. Senate Bill 16 is a housekeeping bill for the Montana Insurance Department.

Stanlee Dull, Secretary of Montana Comprehensive Health Care Association, spoke on SB 16 and presented written testimony. EXHIBIT 2.

Steve Brown, Blue Cross/Blue Shield of Montana, said they support SB 16 as amended and thanked the Commissioner's office for working out the amendments with them. An amendment is on page 22, line 16. As Mr. Barnhill suggested, it should read "require the policies issued to people residing in Montana at one time and subsequently moving to another state will be controlled by the minimum requirements of the Montana law". He did not feel the language accomplishes that objective and felt the language could be construed to mean that the law of the state to which the individual moves becomes the controller. He suggested an amendment which he had checked with the other parties involved, but did not have it written up. The section should read "Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements in Montana law and control over conflicting statutes of any state in which the insured resides on or after the effective date of this policy." This would avoid a situation where someone in Montana buys a policy, but before the policy is actually issued, moves to a state where the benefits were less. The employee was insured in Montana under Montana requirements and should receive the full benefits. Conversely, the insurance company does not want to be put in the position where if an insured moves to some other state and the benefits are double what he is being charged a premium for in Montana, the insurance company might not be able to adjust the premium. If this change is made it should also be made in Sections 23, 24, and 25.

Jacqueline Terrell, American Insurance Association, said they support the property and casualty portion of this bill and specifically support the amendment Mr. Barnhill suggested.

Questions From Committee Members:

REP. ELLIS asked if this meant more clarification for the insured rather than the insurer. SEN. GAGE said not necessarily, there is clarification for the insurer as well.

REP. ELLIS asked SEN. GAGE if most of the changes are to protect the consumer. SEN. GAGE said it does not do a lot for consumer protection, but to the extent they clarify this, it would provide consumer protection. Most of the bill is not very substantive but deals more in the line of clarification of statutory items where people have some concerns about the interpretation.

Closing by Sponsor:

SEN. GAGE concurred with the amendments and had no further closing remarks. REP. PAVLOVICH concurs with the amendment, and hoped it would keep lawyers out of the courts. He will carry SB 16 on the House floor.

HEARING ON SENATE BILL 45

Presentation and Opening Statement by Sponsor:

SEN. BOB BROWN, Senate District 2, said SB 45 was drafted at the request of the Board of Realty Regulation. The bill changes existing law by establishing reciprocal agreements with other states regarding realty licensing. There is new language on page 2 which makes it clear that the bill applies to both those having a broker's license and a salesperson.

Proponents' Testimony:

Marcia Allen, Montana Board of Realty Regulation, said she is a licensed real estate broker. This bill gives the Board of Realty Regulation the authority to enter into agreements for reciprocal licensing with other states. The Board is interested in entering into agreements that will allow Montana licensees to cross state lines, obtain a realty license and work in those states without the requirement of retesting or additional education. Montana would consider other states' licenses equal to ours and would reciprocate with our licensing.

Brendan Beatly, Montana Association of Realtors, said SB 45 will benefit the industry. He expressed support.

Questions From Committee Members:

REP. DOWELL asked if the regulations to become a realtor or get a real estate license are generally consistent from state to state or is there disparity? Ms. Allen said they are quite consistent but Montana probably has less stringent requirements than most states.

REP. LARSON asked if you are a broker and the State of Montana has different brokerage regulations, how does that relate to a two year experience factor? Will that broker be licensed if he is only here for six months after being in Idaho? Ms. Allen said if a person is a broker in Idaho he would be recognized here, but a contractual agreement has to be entered into with the other state.

REP. LARSON asked if this legislation passes will Montana be able to enter reciprocity agreements with the states you are considering? Ms. Allen answered the most interest is with South Dakota. REP. LARSON asked about North Dakota, Wyoming and Idaho. Ms. Allen said the Board will negotiate with their boards.

HOUSE OF REPRESENTATIVES

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

ROLL CALL

DATE Jan 22, 1991

NAME	PRESENT	ABSENT	EXCUSED
REP. JOE BARNETT	✓		
REP. STEVE BENEDICT	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. ALVIN ELLIS, JR.	✓		
REP. STELLA JEAN HANSEN	✓		
REP. H.S."SONNY" HANSON	✓		
REP. TOM KILPATRICK	✓		
REP. DICK KNOX	✓		
REP. DON LARSON	✓		
REP. SCOTT MCCULLOCH	✓		
REP. BOB PAVLOVICH	✓		
REP. JOHN SCOTT	✓		
REP. DON STEPPLER	✓		
REP. ROLPH TUNBY	✓		
REP. NORM WALLIN	✓		
REP. SHEILA RICE, VICE-CHAIR	✓		
REP. BOB BACHINI, CHAIRMAN	✓		

EXHIBIT 1
DATE Jan 22, 1991
SB 16

January 22, 1991
House Business and Economic Development Committee
Senate Bill 16, An Act to Generally Revise Insurance Laws
David Barnhill, Deputy Insurance Commissioner

Good morning, I'm Dave Barnhill, Deputy Commissioner of Insurance. I am representing Andy Bennett, State Auditor and Commissioner of Insurance, in support of SB 16. SB 16 is a housekeeping bill for the Montana Insurance Department.

Section 1. This section deletes the de novo requirement on appeals from orders of the commissioner. The change is at line 14 of page 3. This change would allow the court to review the matter based on the record developed at the administrative level instead of having a new trial. This will save the courts and agency time and expense and bring the Department into line with the appeals process taken from other state agencies.

Section 2. The change is at lines 22 and 23 of page 4. This section separates property/casualty and life/health premium tax bases to take into account different accounting procedures used by the life industry as opposed to the property/casualty industry.

Section 3. The change is at line 3 of page 9. This specifies that the examination fee for a producer license would be paid to the commissioner only if the commissioner conducts the examination. Currently the commissioner contracts with a third party which charges its own examination fee to cover the administrative cost. Some applicants have erroneously believed that they must pay the $15.00 to the Department and a fee to the third party. This is intended to end the confusion.

Section 4. The changes are at line 25 of page 11 and line 1 of page 12. This would provide that assessments upon insurers levied by government agencies other than the Insurance Department are not part of the Montana premium tax. Insurance departments in other states can now assert that assessments levied by the state workers compensation fund on private workers compensation insurers are to be included for purposes of determining the total Montana premium tax rate on these private insurers. This adversely affects the ability of Montana to collect a retaliatory tax.

Section 5. The changes are at lines 9 through 13 of page 13. This declares that domestic insurers must keep records available for inspection by the commissioner. The five year requirement would assure that the records are available during each statutorily mandated examination.

Section 6. The changes are at lines 25 of page 15 and line 1 of page 16. This would allow an interest rate of up to 10% subject to the commissioner's approval on surplus notes. The current 6% rate is not realistic under today's economic conditions.

Section 7. The changes are at lines 16 through 24 of page 17. This would make the penalties for the failure of fraternal insurers to file annual statements the same as the penalties for other insurers who fail to file annual statements on time.

Section 8. The changes at line 15 of page 18 would make explicit that a person applying for a producer license for either disability or life insurance must take the prelicensing education course.

Section 9. The change is found at line 17 of page 19. This would establish a uniform renewal date of July 1st for third party administrators.

Section 10. The change is at line 12 of page 20. This would confirm that the gender of the applicant is not to be considered when issuing annuity or pure endowment contracts.

Section 11. The change is at line 4 of page 21 and line 9 of page 21. The purpose is the same as section 10 to assure that gender is not a factor in the issuing or rating of a pure endowment contract or annuity.

Section 12. Changes in the law are at lines 18 and 19 of page 21 and lines 16 through 21 of page 22. This would require that all master group health insurance policies sold in Montana conform to the laws of Montana.

Sections 13, 14 and 15 at pages 22 through 25. The changes add the term "certificate" to various provisions of Montana's Medicare Supplement Insurance Law. These are designed to guaranty that certificate holders of Medicare supplement policies are afforded the same protection of Montana law as policyholders currently are under Montana. The Department knows of instances

where some companies have argued that certificate holders are not entitled to the protection of Montana law. This would settle that point.

Section 16. The changes in the law are at page 26. This would allow the Montana Comprehensive Health Association to immediately insure someone when it is plain that that person is otherwise uninsurable.

Section 17. The changes in the law are at lines 20 and 21 of page 28. This would prohibit a single member of the Montana Comprehensive Health Association from being able to control that association by having more than 50% of the vote on the board of directors.

Section 18. The changes are at lines 13 through 16 of page 30. This would provide that for purposes of determining assessments to the Montana Comprehensive Health Association, which are based upon premium volume of disability contracts, the assessments be based upon premium volume of true disability insurance policies.

Section 19. The changes are at page 33. The provisions that protect health care providers from termination of liability policies would be extended to alternations of the policies.

Sections 20, 21, and 22, at pages 33 through 36, would require that motor vehicle clubs must file bond or cash deposits with the commissioner rather than the State Treasurer and also that motor club licenses will be continuous rather than annual. These provisions would bring the regulation of motor clubs entirely under the jurisdiction of the Department of Insurance instead of split jurisdiction with the State Treasurer. The State Treasurer recommended these changes.

Sections 23, 24, and 25, at pages 36 and 37, would require that with respect to various lines of insurance, that when the terms of the policies conflict with Montana law, Montana law controls. Policyholders would be given, at a minimum, the protection that Montana law contemplates.

Section 26. The change is at line 10 of page 41. This amendment would provide that the commissioner's authority to regulate managing general agents is extended to those who conduct

DATE 1-22-91
SB 16

Montana Comprehensive Health Association

P.O. Box 5683
HELENA, MONTANA 59604

January 21, 1991

Representative Bob Vachini
Chairman
Business & Economic Development Committee
State of Montana
House of Representatives
Helena, MT 59620

RE: Senate Bill 16

Dear Representative Vachini:

I am writing this letter on behalf of the Board of Directors of the Montana Comprehensive Health Association, an association created pursuant to Title 33, Chapter 22, Part 15, of the Laws of Montana. The Board of Directors met on January 16 and requested that I write you in support of the changes proposed by the State Auditor and Commissioner of Insurance to the law affecting the Montana Comprehensive Health Association. The Board is composed of the seven largest insurers doing business in Montana and one public member appointed by the State Auditor and Commissioner of Insurance. The Directors of the Association and the companies they represent are as follows:

Kirk Cunningham - Principal Financial Group
William N. Jensen - Blue Cross and Blue Shield of Montana
Randall Jones - CNA Insurance Company
Chester Lozowski - Bankers Life & Casualty
Frank Parks - Mutual of Omaha
Bruce Poulsen - Prudential
Scott Wolfley - Federal Home Life Insurance Company

The public member is Stanlee Dull, the Director of the American Diabetes Association, Montana Division.

On behalf of the Board of Directors, I urge that you adopt the changes to Title 33, Chapter 22, Part 15, which are encompassed in Senate Bill 16.

Very truly yours,

William N Jensen

business solely in states other than Montana. This is designed to keep Montana from becoming a safe haven for crooks who would take advantage of persons in other states.

Sections 27, 28, 29, 30, 31, and 32 at pages 42 through 52 are designed to allow all health insurers who are members of the Montana Comprehensive Health Plan to submit bids to be the lead carrier, for purposes of offering and administering the approved association plan.

Section 33. The change is at lines 5 and 6 of page 53. This will require that when the commissioner conducts administrative hearings that the rules of evidence will be used. Current practice conforms to this.

Section 34. The 1989 legislature intended that the term "producer" replace the term "solicitor" in the insurance code. In some instances it was not done. This will finish the job.

This concludes my remarks. I am available for questions. Thank you.

DB/amp(876)

EXHIBIT 2
DATE Jan 22, 1991
SB 16

January 22, 1991

SB-16

Testimony of Stanlee Dull, Secretary of Montana Comprehensive Health Association.

My name is Stanlee Dull. I am the secretary of the Montana Comprehensive Health Association and am appearing on behalf of the Board of Directors of the Association in support of the sections of SB-16 amending the law concerning the Association.

MCHA was created by the 1985 legislature to provide basic health insurance for Montana residents who are medically uninsurable. We presently insure 314 Montana residents. The association is governed by a Board of Directors who are appointed by seven participating members of the association which have the highest annual premium volume of disability (health) insurance contracts. An eighth member at large is appointed by the Commissioner of Insurance. I am the member at large and have served as such since the establishment of the association.

At the Board of Director's request the Commissioner of Insurance has submitted a number of amendments to Title 33, Chapter 22, Part 15 to resolve a number of problems with the administration of the plan. Those amendments are incorporated into the original bill and the amendments submitted by the department.

I will not attempt to discuss the amendments in detail, however, I would like to take a moment and explain why some of the amendments are necessary.

First, a number of the amendments strike the provisions in the law which provide for the submission of what is called a qualified plan by any member of the association and the approval of that plan by the insurance commissioner.

The board learned in applying this provision that there was very little interest in submission of a qualified plan by the members and that only those plans which were interested in becoming a lead carrier would submit such a plan. We felt it better for the Board to adopt a plan which is in compliance with the law, obtain the approval of the Insurance Commissioner's office and then issue a Request for Proposal to allow all members an opportunity to bid on providing this service.

Second, we discovered early that there are a number of medical conditions which make applicants uninsurable by most if not all disability insurers. The code requires that before a person can enroll in the plan, that person must have two letters of rejection by two carriers. The lead carrier's medical director identified

uninsurable. We directed the lead carrier to accept applicants which have one or more of those conditions without the necessity of obtaining letters of rejection. The amendment concerning the waiver of eligibility in section 16 of the bill is to authorize the continuation of this practice.

Third, we identified a problem with the application of the waiver of the preexisting condition clause to certain applicants who come to the association from another plan. During the past several years some carriers have ceased doing business in Montana or became insolvent leaving their insureds without insurance and inadequate time to transfer to MCHA. The amendment proposed in Section 32 allows enrollment without a waiting period for non-elective procedures if an application is submitted within 30 days of cancellation.

Fourth, we discovered a problem with one of the minimum benefits. Section 33-22-1521 excludes organ transplants from coverage under the plan. We discovered that some experts do not consider a bone marrow transplant to be an organ transplant. The amendment in Section 33 provides that bone marrow transplants are to be treated the same as other organ transplants.

Finally, there was an initial problem determining the voting power of the various participants on the Board of Directors. One member had over 70% of the voting power based upon premium volume within the state. The Board resolved this question in its bylaws by providing that no one member cast more than 50% of the vote. The amendment proposed in section 17 formalizes that resolution.

I have attached a letter from the Chairman of the Montana Comprehensive Health Association on behalf of the directors of the association endorsing the changes to the law affecting the Uninsurable Risk Pool.

I hope you will accept the amendments as proposed. I will be happy to answer any questions or, if I am unable to answer them, the attorney for the Insurance Department is can answer questions of a technical nature.

this bill in the Senate Industry Committee and they asked SB 16 be held by the House sponsor until that TPO bill was given a chance to advance, hence the delay.

This bill was reviewed by industry before the Legislative session and there were no objections to it except for that TPO provision which is no longer in it. On the Senate side and here there was no testimony in opposition to it whatsoever. SB 16 refines various miscellaneous provisions of the insurance code and it would be very difficult to review it into a totality since most of the provisions are unrelated. Basically it is a refinement of the code.

Motion: REP. SHEILA RICE moved SB 16 BE CONCURRED IN.

Discussion:

REP. KILPATRICK asked if the fees have been changed or are they the same. Mr. Barnhill said the problem is is that there is a fee to be paid to the insurance department when the insurance department administers the licensing examination. Currently they do not do so, they contract with a third party. People getting licenses think they have to pay a fee to the Auditor's office and to the third party. SB 16 specifies they do not pay a fee to the Auditor when the license examination is administered by a third party. It doesn't change the amount of the fees whatsoever.

REP. WALLIN said that doesn't answer his question about the fees. Mr. Barnhill explained there is no change to the fee whatsoever. There is a $10-15 fee when the insurance department administers the licensing examination. They currently do not do so, nor are they required to do so. The third party that administers the exam charges their own fee, but because this is in the statute, the applicants think they must pay the insurance department and the third party examiner. The department has to return their money, so they want to clarify they are to pay a fee to the department only when they give the exam themselves.

Vote: SB 16 is CONCURRED IN with REPS. BACHINI and SCOTT voting NO. REP. PAVLOVICH will carry SB 16 on the House floor.

ADJOURNMENT

Adjournment: 11:50 a.m.

Bob Bachini
REP. BOB BACHINI, CHAIRMAN

Jo Lahti
JO LAHTI, Secretary

BB/jl

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT

Call to Order: By REP. BOB BACHINI, CHAIRMAN, on April 2, 1991, at 11:30 a.m.

ROLL CALL

Members Present:
Bob Bachini, Chairman (D)
Sheila Rice, Vice-Chair (D)
Joe Barnett (R)
Steve Benedict (R)
Brent Cromley (D)
Tim Dowell (D)
Alvin Ellis, Jr. (R)
Stella Jean Hansen (D)
H.S. "Sonny" Hanson (R)
Tom Kilpatrick (D)
Dick Knox (R)
Don Larson (D)
Scott McCulloch (D)
Bob Pavlovich (D)
John Scott (D)
Don Steppler (D)
Rolph Tunby (R)
Norm Wallin (R)

Members Absent: REP. BOB PAVLOVICH

Staff Present: Paul Verdon, Legislative Council
Jo Lahti, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Announcements/Discussion: This was an executive action meeting on SB 16.

EXECUTIVE ACTION ON SB 16

REP. BACHINI asked Dave Barnhill, Deputy Commissioner of Insurance in the Auditor's Office, to remind the Committee members what the bill does and why it has been held. Mr. Barnhill explained SB 16 is a housekeeping bill of the Insurance Department. This was intended to simply refine various minor problems of the insurance code. It originally contained in it SB 256 which was the preferred provider bill. That was pulled out of

12:45
4-2-91
JDP

HOUSE STANDING COMMITTEE REPORT

April 2, 1991
Page 1 of 1

Mr. Speaker: We, the committee on Business and Economic Development report that Senate Bill 16 (third reading copy -- blue) be concurred in .

Signed: _____
Bob Bachini, Chairman

Carried by: Rep. Pavlovich

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Business & Econ Dev. COMMITTEE BILL NO. SB 16

DATE Jan 22, 1991 SPONSOR(S) Senator Gage

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Jane Bamhill	St. Insurance dept.	SB 16		✓
Jacqueline Terrell	Am Ins. Assoc	SB 16		✓ w/ amdts
Roger McGlenn	IIAM	SB 16		✓
Steve Brown	Blue Cross/Blue Shield	SB 16		✓
Stanley Dunn	MT Comp Health Care Assn	SB 16		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.